		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029645

Facility Name: Crawford County Convalescent

Address: 902 Mefford (Number) Robinson (City) 62454 (Zip Code)

County: Crawford

Telephone Number: 618 546-5638 **Fax #** 618 544-7068

IDPA ID Number: 37-11756262

Date of Initial License for Current Owners: 06/15/1985

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Robert A. Disbrow **Telephone Number:** 217 423-6000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from June 1, 1999 to May 31, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) Robert A. Disbrow, Partner
(Firm Name & Address) Sleeper, Disbrow, Morrison, Tarro & Lively
(Telephone) 217 423-6000 Fax # 217 423-6100

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,764	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	54	TOTALS	54	19,764	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	13,741	3,212		16,953	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,741	3,212		16,953	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.78%

D. How many bed-hold days during this year were paid by Public Aid?
187 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/15/1985

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/15/1985 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 05/31/00 Fiscal Year: 05/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	91,742	4,367	864	96,973		96,973		96,973			1
2	Food Purchase		68,998		68,998	(4,176)	64,822	(1,219)	63,603			2
3	Housekeeping	33,006	7,513		40,519		40,519		40,519			3
4	Laundry	16,736	4,826		21,562		21,562		21,562			4
5	Heat and Other Utilities			35,625	35,625		35,625		35,625			5
6	Maintenance	17,304	13,852	11,413	42,569	641	43,210	(719)	42,491			6
7	Other (specify):*											7
8	**TOTAL General Services**	158,788	99,556	47,902	306,246	(3,535)	302,711	(1,938)	300,773			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	359,894	8,927	270	369,091		369,091		369,091			10
10a	Therapy			4,218	4,218		4,218		4,218			10a
11	Activities	13,664	1,923	442	16,029		16,029		16,029			11
12	Social Services	16,361		442	16,803		16,803		16,803			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	389,919	10,850	5,372	406,141		406,141		406,141			16
	C. General Administration											
17	Administrative	107,000			107,000		107,000		107,000			17
18	Directors Fees											18
19	Professional Services			5,912	5,912		5,912		5,912			19
20	Dues, Fees, Subscriptions & Promotions			1,985	1,985		1,985	(593)	1,392			20
21	Clerical & General Office Expenses		6,800	7,517	14,317		14,317	(361)	13,956			21
22	Employee Benefits & Payroll Taxes			95,104	95,104	4,176	99,280	(15,642)	83,638			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,190	4,190		4,190		4,190			24
25	Other Admin. Staff Transportation			4,097	4,097	(987)	3,110		3,110			25
26	Insurance-Prop.Liab.Malpractice			12,618	12,618		12,618		12,618			26
27	Other (specify):*											27
28	**TOTAL General Administration**	107,000	6,800	131,423	245,223	3,189	248,412	(16,596)	231,816			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	655,707	117,206	184,697	957,610	(346)	957,264	(18,534)	938,730			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Crawford County Convalescent #0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,616	28,616		28,616	1,632	30,248			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,320	7,320		7,320	(7,320)				32
33	Real Estate Taxes			11,956	11,956		11,956	(3,567)	8,389			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			47,892	47,892		47,892	(9,255)	38,637			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					346	346		346			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			100	100		100		100			40
41	Coffee and Gift Shops			1,996	1,996		1,996		1,996			41
42	Provider Participation Fee			29,646	29,646		29,646		29,646			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			31,742	31,742	346	32,088		32,088			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	655,707	117,206	264,331	1,037,244		1,037,244	(27,789)	1,009,455			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(392)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,637)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,632	30		9
10	Interest and Other Investment Income	(7,320)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(827)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(243)	22		18
19	Entertainment				19
20	Contributions	(25)	20		20
21	Owner or Key-Man Insurance	(15,399)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(568)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,649)	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(361)	21		28
29	Other-Attach Schedule **Cellular phone**				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,789)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (27,789)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 346	25	38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 346		47

STATE OF ILLINOIS

Crawford County Convalescent

ID# 0029645

Report Period Beginning: June 1, 1999

Ending: May 31, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Rented Facility Space	$		1
2	Repairs & Maintenance-Rental	(719)	6	2
3	Real Estate Taxes-Rental	(918)	33	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(1,637)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Crawford County Convalescent # 0029645 **Report Period Beginning:** June 1, 1999 **Ending:** May 31, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,219)	0	0	0	0	0	0	0	0	0	0	(1,219)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(719)	0	0	0	0	0	0	0	0	0	0	(719)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,938)	0	0	0	0	0	0	0	0	0	0	(1,938)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(593)	0	0	0	0	0	0	0	0	0	0	(593)	20
21	Clerical & General Office Expenses	(361)	0	0	0	0	0	0	0	0	0	0	(361)	21
22	Employee Benefits & Payroll Taxes	(15,642)	0	0	0	0	0	0	0	0	0	0	(15,642)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(16,596)	0	0	0	0	0	0	0	0	0	0	(16,596)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,534)	0	0	0	0	0	0	0	0	0	0	(18,534)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Crawford County Convalescent **#** 0029645 **Report Period Beginning:** June 1, 1999 **Ending:** May 31, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,632	0	0	0	0	0	0	0	0	0	0	1,632	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,320)	0	0	0	0	0	0	0	0	0	0	(7,320)	32
33	Real Estate Taxes	(3,567)	0	0	0	0	0	0	0	0	0	0	(3,567)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,255)	0	0	0	0	0	0	0	0	0	0	(9,255)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(27,789)	0	0	0	0	0	0	0	0	0	0	(27,789)	45

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dwight Miller	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dwight Miller	President	Administrative	100.00	0	40	100.00	Wages	$ 87,000	17.1	1
2	Ardella Miller	Vice-President	Administrative	100.00	0	40	100.00	Wages	20,000	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 107,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: ay 31, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Dwight Miller	X		Facility Purchase	-	06/15/99	$ 61,000	$ 61,000	06/15/00	12.0000	$ 7,320	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 61,000	$ 61,000			$ 7,320	9
	B. Non-Facility Related*											
10	Interest Income										(7,320)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,320)	14
15	TOTALS (line 9+line14)						$ 61,000	$ 61,000			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	12,166	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	8,825	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,341)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	12,648	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	9,307	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	7,853	8
1996	7,854	9
1997	8,489	10
1998	8,825	11
1999		12

98 taxes pid in '99	$8,825
x 5/12 x 1.04%	3,823
Total Accrual	12,648

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,086 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	31,150	1985	$ 10,000	1
2					2
3	TOTALS	31,150		$ 10,000	3

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1985	1971	$ 558,630	$ 16,333	30	$ 18,621	$ 2,288	$ 279,315	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Storage Building			1985	2,500	167	20	125	(42)	1,875	9
10	Improvements			1985	8,536	427	20	427		6,258	10
11	Hall Remodel			1986	1,238	62	20	62		883	11
12	Air Conditioner			1987	5,775	289	20	289		3,780	12
13	Lobby Remodel			1985	2,965		10			2,965	13
14	Office - House			1985	15,000	750	20		(750)	7,500	14
15	Generator			1988	12,182	609	20	609		7,207	15
16	Reroof Building			1989	17,110	1,141	15	1,141		12,833	16
17	Air Conditioner			1989	6,400		10			6,400	17
18	Hall Remodel			1990	2,568	257	10	257		2,440	18
19	Storage Building			1992	7,114	474	10	474		3,595	19
20	Storage Building - Additions			1993	2,170	144	15	144		1,015	20
21	Roof-North Wing			1995	9,376	625	15	625		3,281	21
22	Electromagnetic Locks			1996	6,412	641	10	641		2,831	22
23	Window Replacments			1996	8,478	565	15	565		1,930	23
24	Automatic Doors			1998	4,975	331	15	331		580	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 671,429	$ 22,815		$ 24,311	$ 1,496	$ 344,688	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 48,513	$ 5,076	$ 5,212	$ 136	8 years	$ 29,745	37
38	Current Year Purchases	4,895	87	87		12 years	87	38
39	Fully Depreciated Assets	96,681					96,681	39
40								40
41	TOTALS	$ 150,089	$ 5,163	$ 5,299	$ 136		$ 126,513	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Staff Transportation	1997 Ford Escort	2000	$ 7,650	$ 638	$ 638	$	4 years	$ 638	42
43	Resident Transportation	Handicap Lift Bus	1990	7,500				4 years	7,500	43
44										44
45										45
46	TOTALS			$ 15,150	$ 638	$ 638	$		$ 8,138	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 846,668	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 28,616	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 30,248	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 1,632	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 479,339	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of May 31, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 284,683	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	182,414		3
4	Supply Inventory (priced at)	5,584		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,694		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 486,375	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000		13
14	Buildings, at Historical Cost	602,797		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	207,718		16
17	Accumulated Depreciation (book methods)	(493,066)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Tax Deposit	57,931		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 410,380	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 896,754	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 23,526	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,121		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,182		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,648		32
33	Accrued Interest Payable	7,320		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	2,649		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 64,446	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	61,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 61,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 125,446	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 771,308	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 896,754	$	48

***(See instructions.)**

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 717,630	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 717,630	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	187,542	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(133,864)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 53,678	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 771,308	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,210,107	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,210,107	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,100	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	392	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,492	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,585	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,585	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Parking Lot Rental	144	28
28a	Loss on equipment disposal	(542)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (398)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,224,786	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	306,246	31
32	Health Care	406,141	32
33	General Administration	245,223	33
	B. Capital Expense		
34	Ownership	47,892	34
	C. Ancillary Expense		
35	Special Cost Centers	2,096	35
36	Provider Participation Fee	29,646	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,037,244	40
41	**Income before Income Taxes (line 30 minus line 40)****	187,542	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 187,542	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,056	2,096	$ 44,126	$ 21.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,653	5,757	77,999	13.55	3
4	Licensed Practical Nurses	4,730	4,890	59,738	12.22	4
5	Nurse Aides & Orderlies	27,553	27,753	178,031	6.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,116	2,116	13,664	6.46	9
10	Activity Assistants					10
11	Social Service Workers	1,824	1,952	16,361	8.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,189	2,245	28,021	12.48	14
15	Cook Helpers/Assistants	11,042	11,090	63,721	5.75	15
16	Dishwashers					16
17	Maintenance Workers	2,473	2,513	17,304	6.89	17
18	Housekeepers	5,722	5,802	33,006	5.69	18
19	Laundry	2,332	2,412	16,736	6.94	19
20	Administrator	2,056	2,096	87,000	41.51	20
21	Assistant Administrator	2,056	2,096	20,000	9.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	71,802	72,818	$ 655,707 *	$ 9.00	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	48	$ 864	1.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	50	2,651	10A.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	442	11.3	44
45	Social Service Consultant	10	442	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	118	$ 4,399		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dwight Miller	Administrator	100%	$ 87,000
Ardella Miller	Asst Admin	100%	20,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
A Better Way	Payroll	$ 695
Sleeper, Disbrow et al	Accounting	2,775
Mid-America Programming	Computer Support	1,320
Yassin	Medical Consultant	1,000
Duane, Morris & Heckscher	Legal	122
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 5,912

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,087
Unemployment Compensation Insurance	4,745
FICA Taxes	50,150
Employee Health Insurance	3,936
Employee Meals	4,176
Illinois Municipal Retirement Fund (IMRF)*	
Christmas	544
TOTAL (agree to Schedule V, line 22, col.8)	$ 83,638

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	194
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues	407
Subscriptions	307
Business Licenses	484
Promotional Advertisement	567
Contributions	25
Less: Public Relations Expense	(25)
Non-allowable advertising	(567)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,392

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,773
Seminar Expense	1,417
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,190

**See instructions.

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Crawford County Convalescent # 0029645 Report Period Beginning: June 1, 1999 Ending: May 31, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Attached**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **12 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **29,646**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,176** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **392**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **10%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Crawford County Convalescent Center
Schedule V
Line 24 - Travel and Seminar

Individual (s) Attending Seminar	Job Title	Dates Attended	Location	Title of Seminar	Sponsor of Seminar	Cost
Dwight Miller	Administrator	May 13, 1999	Springfield, IL	INHAA Conference	IL Nursing Home Administrator's Association	$ 95
Dwight Miller	Administrator	July 21, 1999	Chicago, IL	Long Term Care Advisory Board	IL Dept of Public Health	512
Dwight Miller Ardella Miller	Administrator Asst. Administrator	Aug. 18-19, 1999	Bloomington, IL	INHAA Conference	IL Nursing Home Administrator's Association	463
Dwight Miller	Administrator	Aug. 24, 1999	Chicago, IL	IDM Classification Review	IL Dept of Public Health	379
Dwight Miller	Administrator	Sept. 13-15, 1999	Peoria, IL	Annual Convention/ Trade Show	IL Health Care Assoc.	205
Dwight Miller	Administrator	Nov. 3, 1999	Rockford, IL	INHAA Related Meeting	INHAA Board	150
Andrea Plew	RN, FSS	Correspondence Course		Dietary Manager Course	University of North Dakota	447
Dwight Miller Ardella Miller Barbara Hancock Andrea Plew	Administrator Asst. Administrator RN, DON RN, FSS	Nov. 10-11, 1999	East Peoria, IL	INHAA Conference	IL Nursing Home Administrator's Association	459
Dwight Miller	Administrator	Nov. 23, 1999	Rockford, IL	INHAA Related Meeting	INHAA Board	148
Dwight Miller	Administrator	Dec. 13, 1999	Decatur, IL	Facility Related Business		55
Dwight Miller Ardella Miller	Administrator Asst. Administrator	Feb. 10, 2000	Naperville, IL	INHAA Conference	IL Nursing Home Administrator's Association	385
Dwight Miller Ardella Miller Barbara Hancock Andrea Plew	Administrator Asst. Administrator RN, DON RN, FSS	April 11-12, 2000	Springfield, IL	INHAA Conference	IL Nursing Home Administrator's Association	743
Ardella Miller Barbara Hancock	Asst. Administrator RN, DON	April 19, 2000	Springfield, IL	MDS Correction Policy	IL Health Care Assoc.	100
Ardella Miller Barbara Hancock	Asst. Administrator RN, DON	April 26, 2000	East Peoria, IL	HFCA 2000 - Are You Ready	Mid-America Programming	50
					Total	$ 4,190

Crawford County Convalescent Center
Schedule V
Line 25 - Other Admin. Staff Transportation

Description of cost	Cost
Fuel and oil for van and bus	$ 2,432
Repairs and maintenance for van and bus	774
License for van and bus	250
Repairs and maintenance for mower	641
Total for general ledger	4,097
Reclassified to maintenance	(641)
Subtotal	3,456
Reclassified to medically necessary transportation	(346)
Adjusted total	$ 3,110

Crawford Count Convalescent Center
Reclassification Entries
May 31, 2000

Line No.	Line	Debit	Credit
	-1-		
22-5	Employee Benefits & Payroll Taxes	4,176	
2-5	Food Purchase		4,176
	(To reclassify employee meals)		
	-2-		
6-5	Maintenance	641	
38-5	Medical Necessary Transportation	346	
25-5	Other Admin. Staff Transportation		987
	(To reclassify lawn mower repairs and medical necessary transportation)		

Crawford Count Convalescent Center
Schedule XVII
Reconcilation of taxable income

Net Income - Line 41	$	187,542
Adjustment for contributions reported on Schedule K-1		25
Adjustment for health insurance expense reported on Schedule K-1		15,399
Adjustment for interest income and rental income reported on Schedule K-1		(12,010)
Depreciation differences		(965)
Penalties		243
Gain on sale of equipment differences		644
Federal taxable income	$	190,878

The Board of Directors
D. Miller Innovative Care, Inc.
d/b/a Crawford County Convalescent Center

We have compiled the accompanying balance sheet (Schedule XV) of D. Miller Innovative Care, Inc., d/b/a Crawford Convalescent Center, as of May 31, 2000, the related income statement (Schedule XVII) and statement of changes in equity (Schedule XVI), and the financial information contained in Schedules I through XIV, and XVIII through XX for the year then ended included in the accompanying prescribed form of the State of Illinois Department of Public Aid Financial and Statistical Report for Long-Term Care Facilities in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

Our Compilation was limited to presenting in the form prescribed by the State of Illinois information that is the representation of management. We have not audited or reviewed the financial statements and schedules referred to above, and accordingly, do not express an opinion or any other form of assurance on them.

The financial statements and schedules are presented in accordance with the requirements of the State of Illinois, Department of Public Aid, which differ from generally accepted accounting principles. Accordingly, these financial statements and schedules are not designed for those who are not informed about such differences.

Decatur, Illinois
September 5, 2000

Crawford County Convalescent Center
Schedule XX
Question 2

National Activity Association	$	59
Activity Professional Association		25
IL Nursing Home Admin.		225